REQUEST FOR PAYMENT/OVERRIDE FORM

This form will be used for:	Request for Payment of Transition Intensive Support Coordination

Participant Name: _____ Medicaid # (13 digits:) _____ Date of Birth: / /

Agency Name: _____ Agency Contact Person: _____ Agency Ph: ( ) -

Agency Fax: ( ) - Agency E-mail Address: _____

Provider Number: _____ Region: _____ Population: (Check One) EDA _____ ADHC _____

Recipient Linkage Date: / / TISC Begin Date: / / TISC End Date: / / Date Recipient Transitioned Home: _____

ATTACH THE FOLLOWING DOCUMENTS NECESSARY TO JUSTIFY REQUEST: (DHH may request additional information.) Check documents that are attached:

CMIS 1500: _____ CPOC Budget Sheet: _____ CMIS Service Logs: _____

DHH WILL NOT OVERRIDE TIMELY FILING LIMITS. IT IS THE RESPONSIBILITY OF EACH AGENCY TO RECONCILE ALL BILLINGS IN A TIMELY MANNER. DHH WILL REQUIRE A MAXIMUM OF FORTY-FIVE (45) CALENDAR DAYS TO PROCESS ALL REQUESTS AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION. ANY REQUEST NOT CONTAINING THE NECESSARY INFORMATION WILL BE RETURNED AS INCOMPLETE AND CONSIDERED NOT RECEIVED.

THIS SECTION TO BE COMPLETED BY OAAS:

RECCOMMENDED FOR APPROVAL BY OAAS DATE: / /

RECOMMENDED FOR DENIAL BY OAAS DATE: / /

DATE REQUEST RETURNED TO AGENCY: (See Reason Below): / /

If Denied or Returned, please provide reason: _____

_____

_____

_____

_____ _____

Signature and Title of OAAS Regional Manager or Designee Date

THIS SECTION TO BE COMPLETED BY DHH/WAIVER ASSISTANCE AND COMPLIANCE (WAC):

APPROVED: _____ DENIED: _____ RETURNED (See Reason Below): _____

If Denied or Returned, please provide reason: _____

_____

_____

_____ _____

Signature of DHH/WAC Authorized Reviewer Date